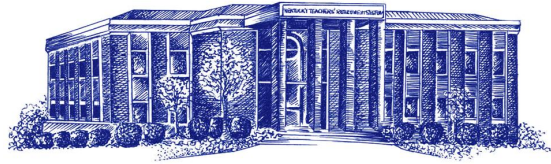


TEACHERS' RETIREMENT SYSTEM OF KENTUCKY

GARY L. HARBIN, CPA
Executive Secretary
502/848-8500



SERVING KENTUCKY TEACHERS SINCE 1940

ROBERT B. BARNES, JD
Deputy Executive Secretary
Operations and General Counsel

J. ERIC WAMPLER, JD
Deputy Executive Secretary
Finance and Administration

MEMORANDUM

TO: KTRS Retirees

FROM: KTRS Insurance Department

RE: **Dropping Dependents**

Outside of open enrollment, retirees may be allowed to drop a spouse and/or dependents from their plan ***IF a qualifying event (QE) has occurred and the required application/form is signed within 35 days.*** Please see the attached QE Chart.

If a qualifying event has occurred, you should complete the attached "Drop Form" to make the appropriate change and return it **with the required documentation** (see QE Chart). Be mindful of the date you sign to avoid double coverage or a lapse of coverage, but ***no later than 35 days*** from the qualifying event.

NOTE: If your qualifying event allows you to change your Option (Standard PPO, Capitol Choice, Optimum PPO), and you desire to do so, you must complete an ***application*** instead of a Drop Form.

If you have and questions, please contact this office.

3-1-2010

QUALIFYING EVENT (QE) CHART WITH DOCUMENTATION REQUIREMENTS TO DROP/TERMINATE

Rev 11/09

Event	Event Description	FORM REQUIRED	DOCUMENTATION REQUIRED	Effective Date
Change in Legal Marital Status				
Marriage	Drop retiree/dependents if person becomes covered under spouse's plan (10)(12)	DROP Form	Proof of obtaining other coverage - must list name and effective date (15)	End of month from retiree's signature date
Divorce, Legal separation, annulment	Drop spouse; also drop dependents added to former spouse's plan (12)	DROP Form	Filed decree signed by a judge and date-stamped "Filed"	End of the month of loss of eligibility
Spouse's death	Drop Spouse (12)	DROP Form	None	End of the month of death
Change in Number of Dependents				
Number of retiree's eligible dependents decreases (i.e. by death or because child becomes ineligible)	Drop affected dependent (12)	DROP Form	None	End of the month of loss of eligibility
Change in Retiree's Employment Status				
Retiree terminates retirement	Insurance coverage automatically terminated	None	None	End of the month of loss of eligibility
Retiree gains other Employer-Sponsored Group Health Insurance Coverage	Terminate coverage (10)	Application to Waive	Letter from employer naming covered persons and effective date OR Insurance card for each person dropping <u>must state insurance effective date</u> (15)	End of month from retiree's signature date
Change in Spouse or Dependent Employment Status				
Spouse or dependent gains other Employer-Sponsored Group Health Coverage (by commencing employment, returning to work after a strike or lockout, returning from unpaid leave, gaining eligibility under employer's plan, etc.)	Drop retiree, spouse, or dependent who becomes covered under spouse's or dependent's plan (7)(10)(12)(15)	Insurance application to Waive (<u>for retiree</u>) OR DROP Form (<u>SP or Dep</u>)	Letter from employer on company letterhead naming persons covered and the date insurance becomes effective OR Copy of new health insurance card <u>with coverage effective date</u> (15)	End of month from retiree's signature date
Other change in employment status that causes spouse or dependent to gain eligibility for coverage under spouse's or dependent's plan (i.e. switch from hourly to salaried status)	Drop coverage for retiree, spouse, or dependent who becomes covered under spouse's or dependent's plan (10)(12)	Insurance application to Waive (<u>for retiree</u>) OR DROP Form (<u>SP or Dep</u>)	Letter from employer on company letterhead naming persons covered and the date insurance becomes effective OR Copy of new health insurance card <u>with coverage effective date</u> (15)	End of month from retiree's signature date
Change in Dependent Eligibility				
Dependent ceases to satisfy plan eligibility requirements (on account of age, marriage, support & maintenance, etc.)	Drop coverage for dependent (12)	DROP Form	None	End of the month of loss of eligibility

Change in Residence				
Retiree, spouse, or dependent changes primary (6) residence and becomes ineligible for KEHP	Terminate retiree, spouse, and dependent	Insurance Application to Waive	None	End of the month of loss of eligibility
Other Events				
Retiree, spouse, or dependent becomes entitled to Medicare	Drop coverage for person who gains Medicare	Insurance application to Waive (for retiree) OR DROP Form (SP or Dep)	Copy of Medicare card OR Initial eligibility letter from Medicare Office	End of month from retiree's signature date
Retiree, spouse, or dependent becomes entitled to Medicaid	Drop coverage for person who gains Medicaid	Insurance application to Waive (for retiree) OR DROP Form (SP or Dep)	Initial eligibility letter from Medicaid AND Medicaid Eligibility/Termination Form	End of month from retiree's signature date
Change in Coverage Under Another Employer Plan				
Retiree or spouse makes elections during an open enrollment period that differs from the open enrollment of the employer (7)	Retiree can make election change that "corresponds" with open enrolment election (10)	Insurance Application to Waive OR DROP Form	Employer letter that identifies the open enrollment period dates, the effective date of coverage or termination, and the persons who will be covered by the plan	End of month from retiree's signature date

End Notes:

- (1) The final regulation preamble indicates that dependents who can be added are those who were directly affected by the status change event plus other dependents (the so-called "tag-along" rule). However, the examples in the regulation only explicitly deal with situations where an employee elects family coverage and adds family members at no additional cost. It is not clear, but IRS staff members have informally stated that the "tag-along" rule applies even if the employee must increase an election to add additional dependents. Also, the preamble and examples in the regulation indicate that the "tag-along" rule applies to HIPAA events and situations where a spouse terminates employment; it is not clear what other events might be covered by the "tag-along" rule.
- (5) For purposes of eligibility in this plan, a divorced dependent is not an "unmarried" dependent
- (6) Primary residence is the official residence claimed for tax purposes.
- (7) Military Insurance Coverage is considered "Another Employer Plan", however, Veteran's Administration (VA) benefits are **NOT** considered "Another Employer Plan".
- (10) Supporting documentation required.
- (11) HIPAA Special Enrollment Right.
- (12) Qualifying Event permits change in plan option (Standard, Capitol Choice, and Optimum). (Retiree must request an **application** instead of Add or Drop Form.)
- (13) Loss of Coverage letter (on letterhead) must state the date insurance terminates as well as list the name(s) of those losing coverage. Hand-written documentation will not be accepted.
- (14) Letter from insurance company should identify type of insurance coverage, reason for coverage ending, and persons who were covered by the policy. Hand-written documentation will not be accepted.
- (15) Letter from employer on company letterhead naming persons covered and the date insurance becomes effective **OR** copy of new health insurance identification card with same information, Hand-written documentation will not be accepted.

QUALIFYING EVENT FORMS SHOULD BE SIGNED WITHIN 35 DAYS OF THE QE

Kentucky Teachers' Retirement System

479 Versailles Road
Frankfort, KY 40601
(502) 848-8500
(502) 573-0199 Fax



2010 DEPENDENT DROP FORM

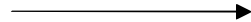
This form must be used for any qualifying event (QE) that allows you to drop dependents from your plan. (You must complete an Enrollment Application to request other coverage election changes such as electing new coverage, option changes, new waiver or to cease a cross-reference plan.)

Planholder's SSN

Cross-Ref Y/N

Company Number

Retiree Name (First, MI, Last) _____

To be eligible to drop a dependent from your health insurance plan, you must certify that you have experienced the QE as listed here. 
By signing this form you are also certifying that you are not under any administrative order to cover the dependent(s) on your health plan.

NOTE: DEPENDENTS WILL BE DROPPED FROM YOUR PLAN AT THE END OF THE MONTH OF THE SIGNATURE DATE ON THIS FORM, BUT NOT BEFORE THE EVENT DATE.

Exceptions:

- ❖ **Death:** dependent will be dropped effective the date of death.
- ❖ **Ineligible Dependents:** ineligible dependents will be dropped from the plan at the end of the month in which they become ineligible.

Qualifying Events: (Check one)

- ☐ Divorce*/Legal Separation*/Annulment* (35 Days)
- ☐ Legal Guardianship/Admin Order/Court Order*+
- ☐ Spouse/Dependent/Retiree's Death
- ☐ Dependent child becomes ineligible (35 Days)
- ☐ Spouse/Dependent gains employer-sponsored Group Coverage* (35 Days)
- ☐ Sp/Dependent ends LWOP* (resumes coverage)
- ☐ Sp/Dep becomes eligible for Medicare* (35 Days)
- ☐ Sp/Dep becomes eligible for Medicaid* (35 Days)
- ☐ Sp/Retiree has a different open enrollment period*+
- ☐ Other _____

Qualifying Event Date (mm/dd/yy): _____

Note: SP = Spouse DEP = Dependent

*Supporting documentation required

+Refer to QE chart for rules/effective dates

PRINT the following information for each dependent to be dropped. If dropping self, you must complete an Enrollment Application.

Social Security Number	Name (First, MI, Last)	Gender (Circle One)	Date of Birth	Relationship Code **
		M F		
		M F		
		M F		
		M F		

** Relationship Code: SP = Spouse / CH = Child / CO = Court Ordered Dependent / DD = Disabled Dependent

I acknowledge and understand that DEI will comply with the HIPAA Rules and that disclosure of information will be done under the rules of such Federal law. I further authorize DEI to use such information to third party administrators, vendors, consultants, governmental authorities with jurisdiction and other necessary parties when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities.

My signature below certifies that I understand the statements on this form and that all the information provided by me is true and complete to the best of my knowledge. I understand that any person who knowingly and with intent to defraud any insurance company or other person, files this form containing any materially false information or conceals, with the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. I understand that any material misrepresentation or material omission contained herein may be used to void this contract.

Retiree Signature

Date

Retiree's Insurance Coordinator Signature

Date

Signatures are required below if changes to an existing cross-reference plan are being requested.

Spouse or Applicant Signature

Date

Spouse's Insurance Coordinator Signature

Date

Revision Date: 11/3/2009